

AMBULATORY SURGICAL CENTER SERVICES PAYMENT SYSTEM

payment**basics**

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Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures in 2010 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and other eye procedures. According to preliminary estimates from the Centers for Medicare & Medicaid Services (CMS), Medicare payments to ASCs were \$3.5 billion in 2011, including both program spending and beneficiary cost sharing.

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a new payment system based on the hospital outpatient prospective payment system (OPPS). (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) Like the OPPS, the ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. Beneficiaries are responsible for paying 20 percent of the ASC payment rate.

Defining the products that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the approximately 3,500 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. There are several hundred APCs. All services within an APC have the same payment rate. The ASC system uses the same payment groups (APCs) as the OPPS.

Within each APC, CMS packages most ancillary items and services with the primary service. CMS pays separately for certain ancillary items and services when they are integral to surgical procedures:

- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- many drugs.

In addition, ASCs can receive separate payments for implantable items that are eligible for pass-through payments under the OPPS. Pass-through payments are for specific, new technology items that are used in the delivery of services. The purpose of these payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS rates.

In 2008, CMS substantially expanded the list of services that qualify for facility payment in ASCs. Medicare began paying for all procedures that do not pose a significant safety risk when performed in an ASC *and* do not require an overnight stay. CMS updates the list of approved procedures annually. Previously, CMS applied more stringent criteria to determine which surgical procedures would receive payment in ASCs.

Setting the payment rates

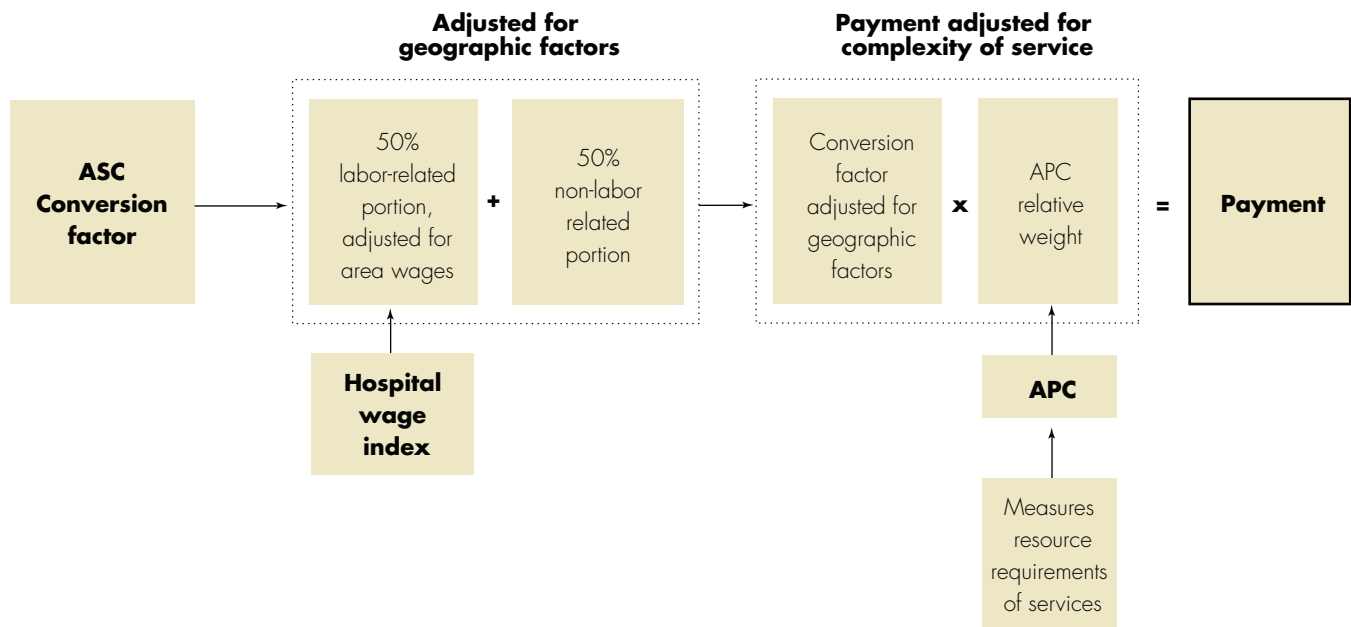
The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. These weights are based on the median cost of the services in that payment group according to outpatient hospital cost data. The ASC system uses a conversion factor to translate the relative weights into dollar amounts. The ASC conversion factor is less than the OPPS conversion factor for the following reasons. First, CMS set the initial

*This document does not
reflect proposed legislation
or regulatory actions.*

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Figure 1 Ambulatory surgical center services payment system



Note: ASC (ambulatory surgical center), APC (ambulatory payment classification). The APC is the service classification system for the outpatient prospective payment system and ASC payment system. CMS uses methods different from the one shown here to set payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures (where the cost of the device accounts for more than half of the total procedure payment). For example, payment for new, office-based procedures and separately payable radiology services equals the lower of the ASC rate (as determined by the method shown above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service).

ASC conversion factor for 2008 so that total ASC payments under the new payment system would equal what they would have been under the payment system in effect before 2008. By comparison, the initial OPPS conversion factor was based on total payments for hospital outpatient services in 2000. Second, CMS uses different update factors to account for changes in input prices for ASCs and hospitals. The 2012 ASC conversion factor is \$42.63, which is 60.8 percent of the OPPS conversion factor. Consequently, the ASC rates are less than the OPPS rates.

CMS uses methods different from the one described above to set ASC payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures. New, office-based procedures are services that CMS began paying for in ASCs in 2008 or later that

are performed in physician offices at least 50 percent of the time. Payment is the lower of the ASC rate (based on the methodology described above) or the practice expense portion of the physician fee schedule rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service). In capping ASC rates at physician fee schedule rates for these services, CMS seeks to minimize financial incentives to shift services from physician offices to ASCs. CMS applies the same policy to separately payable radiology services. When separately-payable drugs are provided in ASCs, CMS pays ASCs the same amount it pays under the OPPS.

Device-intensive procedures are defined as OPPS services for which the device cost is packaged into the procedure payment and the cost of the device accounts for

more than half of the total payment (such as a spine infusion pump). When these procedures are provided in ASCs, CMS divides the payment for these services into a device portion (which includes the cost of the device) and a non-device portion. CMS pays the ASC the same amount it would pay under the OPPS for the device portion of the service but pays 60.8 percent of the OPPS amount for the non-device portion of the service.

To account for geographic differences in input prices, CMS adjusts the labor portion of the ASC rate (50 percent) by the hospital wage index. CMS does not adjust the non-labor portion (the remaining 50 percent). A survey of ASCs conducted by the Government Accountability Office determined that labor accounts for about 50 percent of ASC costs.

As in the OPPS, ASC payment rates are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

CMS updates the ASC relative weights annually based on changes to the OPPS procedure groups and relative weights and the physician fee schedule practice expense amounts. CMS annually reviews and revises the OPPS procedure groups and their weights. The review considers

changes in medical practice and technology, the addition of new services, new outpatient cost data, and other information.

Because the OPPS relative weights usually change each year by a small amount, CMS adjusts the new OPPS weights so that projected program spending based on the current mix of services does not change. However, the mix of services in ASCs differs from that of hospital outpatient departments. Therefore, using the new OPPS relative weights could increase or decrease total ASC spending. To ensure that ASC spending does not change as a result of the new weights, CMS adjusts each ASC relative weight by the same scaling factor. This factor in 2012 is 0.9466; in other words, each ASC weight is reduced by 5.3 percent. This scaling factor does not apply to ancillary items and services that are paid separately, such as separately-paid drugs.

In 2012, the ASC conversion factor was increased by 1.6 percent, based on a 2.7 percent increase in the consumer price index for all urban consumers (CPI-U), which CMS uses to update ASC rates, minus a 1.1 percent deduction for multifactor productivity growth. The Patient Protection and Affordable Care Act of 2010 requires that, beginning in 2011, the annual update for ASC services (based on the CPI-U) must be reduced by a productivity adjustment. ■